Letters to the Editor

Body Substance Isolation

To the Editor:

The proponents of the Body Substance Isolation (BSI) system continue to overlook several important issues regarding the mode(s) of transmission of certain potential pathogens.' BSI is probably satisfactory as an extension or in place of Universal Precautions for patients without signs or symptoms of infection. But when a patient has diarrhea, possibly from an enterovirus or *Clostridium difficile,* or a patient is colonized or infected with methicillin-resistant *Staphylococcus aureus,* the patient's body substances are not the only areas where these organisms are located. They also are present on the patient's linens, furniture, and other articles, and are thus transferred to the clothing and hands of personnel, even if there is no direct contact with the infected or colonized body substance.

Thus, physicians and nurses who sit in the patient's chair or lean against the bed are likely to find these organisms on their clothing, hands, patient's chart, and their stethoscope, and then transport them to the next patient.

BSI is "extended" by strict isolation for varicella. What about isolation for other airborne organisms not necessarily transmitted via contact with body substances? They are not transmitted only by body substances. They require masks even if no splashing is likely (i.e., *Mycobacterium tuberculosis* or *Meningococcus)* .

In our institution, we have retained the card-related categories for another reason. It is often the only way we become aware of patients who develop nosocomial infections (e.g., intravenous site-related infections or wound infections that are not cultured and occur in patients who are only moderately febrile). Our nursing staff is very conscientious about sending us preprinted slips to inform us why they institute isolation or precautions, and thus we have a much more accurate nosocomial infection rate than we would otherwise have.

I feel that BSI is fine for long-term facilities where the types of infections are limited, but not for acute care hospitals. When everyone is on the same "isolation," there is nothing to alert people who only have an occasional contact with the patient that special precautions may be needed. BSI may be easier on the staff, but it does not meet the needs of preventing transmission of organisms that are not part of our normal flora, and thus does not protect patients.

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REFERENCE

1. Jackson MM, Lynch I? An attempt to make an issue less murky: a comparison of four systems for infection precautions. *Infect Control Hosp Epidemiol.* 1991;12:448-450.

The authors reply.

Our article' contained only a brief description of each isolation system; the Table contained several examples of various infectious diseases and compared the general management strategy that each system would recommend. The examples in the Table were not meant to be comprehensive. However, similar conditions would be handled in a similar fashion. For example, varicella and the childhood airborne communicable diseases, except for tuberculosis, are handled similarly. Body Substance Isolation (BSI) does not use strict isolation for varicella or other airborne communicable diseases because transmission of these diseases is not affected by apparel; patients likely to be infected receive care from immune healthcare workers in private rooms or with immune roommates.

Recently, the Centers for Disease Control published new recommendations for reducing the risk for transmission of tuberculosis.[2] Masks that filter particles the size of *Mycobacterium tuberculosis* have been developed; surgical masks do not accomplish this, and

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